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Kai T. Erikson

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Patient Role and Social Uncertainty—A Dilemma of the Mentally Ill†

Kai T. Erikson*

THE CONCEPT of role has become widely used in the field of mental health to relate the behavior of mental patients to the social setting of their illness. The literature in which this concept has appeared, however, has been largely concerned with the specialized culture of the mental hospital—the formal and informal structures of ward life—almost as if the universe to which a patient relates when he enacts a "patient role" is neatly contained within hospital walls.[1] To the sociologist, who generally uses the concept of role in a broader social context, this tends to place a one-sided emphasis on the institution itself as the essential focus of the patient's social life.

When a person enters a mental hospital for treatment, to be sure, he abandons many of the social ties which anchored him to a definite place in society. However, the act of becoming a mental patient effects a fundamental *change* in the person's relationship to the ongoing processes of society, not a complete withdrawal from them; and while the forms of his participation are altered, he remains acutely sensitive to outer influences. Even in the relative isolation of the hospital ward, then, the patient's behavior to some extent articulates his relationship to the larger society and reflects the social position which he feels is reserved for him in its organizational structure. It is this aspect of the role of the patient which the present paper will consider.

Definitions

Role usually is used to designate a set of behaviors or values about behavior which is commonly considered appropriate for persons occupying given statuses or positions in society. For the purposes of this paper, it will be useful to consider that the acquisition of roles by a person involves two basic processes: *role-validation* and *role-commitment.* Role-validation takes place when a community 'gives' a person certain expectations to live up to, providing him with distinct notions as to the conduct it considers appropriate or valid for him in his position.[2] Role-commitment is the complementary process whereby a person adopts certain styles of behavior as his own, committing himself to role themes that best represent the kind of person he assumes himself to be, and

[2] Validation, it might be pointed out, is meant to be more than a community's attempt to impose its moral preferences upon members. The community may validate certain behavior as appropriate for certain individuals even while remaining completely outraged by it. By naming a criminal "habitual" or "confirmed," for instance, people declare their intention of punishing him, not because his conduct violates their expectations or is "unlike" him, but precisely because it *is* like him and is thus the valid way for him to act.

* B.A., Reed Coll. 53; M.A. Univ. of Chicago 55. Grant Foundation Fellow, Family Study Center, Univ. of Chicago 54-55; Dept. of Psychiatry, Walter Reed Army Inst. of Research, Washington, D. C. 55-56; Mental Hygiene Consultation Service, Fort Dix, N. J. 56-.

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[1] See, for example, the following: J. F. Bateman and H. W. Dunham, "The State Hospital as a Specialized Community Experience," *Amer. J. Psychology* (1948) 105:445-448; William Caudill, Fredrick C. Redlich, Helen R. Gilmore, and Eugene B. Brody, "Social Structure and Interaction Processes on a Psychiatric Ward," *Amer. J. Orthopsychiatry* (1952) 22:314-334; George Devereux, "The Social Structure of the Hospital as a Factor in Total Therapy," *Amer. J. Orthopsychiatry* (1949) 19:493-500; Howard Rowland, "Interactional Processes in a State Mental Hospital," PSYCHIATRY (1938) 1:323-337; Alfred Stanton and Morris S. Schwartz, "Medical Opinion and the Social Context in the Mental Hospital," PSYCHIATRY (1949) 12:243-249; Stanton and Schwartz, *The Mental Hospital;* New York, Basic Books, 1954.

best reflect the social position he considers himself to occupy.

Normally, of course, these processes take place simultaneously and are seldom overtly distinguished in the relationship between the person and his community. The person learns to accept the image that the group holds up to him as a more or less accurate reflection of himself, is able to accept as his own the position which the group provides for him, and thus becomes more or less committed to the behavior values which the group poses as valid for him. The merit of making a distinction between these two processes, then, is solely to visualize what happens in marginal situations in which conflict does occur—in which the person develops behavior patterns which the community regards as invalid for him, or the community entertains expectations which the person feels unable to realize. Sociologists, traditional specialists in this aspect of deviance, have generally been more concerned with the process of validation than that of commitment, concentrating on the mechanisms which groups employ to persuade individuals that roles validated for them deserve their personal commitment.

In so doing, sociologists have largely overlooked the extent to which a person can *engineer* a change in the role expectations held in his behalf, rather than passively waiting for others to 'allocate' or 'assign' roles to him. This he does by being so persistent in his commitment to certain modes of behavior, and so convincing in his portrayal of them, that the community is persuaded to accept these modes as the basis for a new set of expectations on its part.

Thus the process by which persons acquire a recognized role may, at times, involve long and delicate negotiations between the individual and his community. The individual presents himself in behavior styles that express his personal sense of identity and continuity; [3] the group validates role models for him that fit its own functional needs.[4] The negotiation is concluded when a mutually satisfactory definition of the individual is reached and a position established for him in the group structure—or when the issue becomes stalemated and suppressive sanctions against deviance are called into play.

The argument to be presented here is that such a negotiation is likely to follow a mental patient's admission to a mental hospital, particularly if he does not qualify as a "certified" patient with a circumscribed disease. In accepting hospitalization, the patient is often caught in the pull of divergent sets of expectations: on the one hand, he is exposed to psychiatry's demand that he make a wholehearted commitment to the process of treatment, and, on the other, he is confronted by a larger society which is often unwilling to validate these commitments. He is left, then, with no consistent and durable social role, with no clear-cut social models upon which to fashion his behavior. The patient is thus often persuaded by the logic of psychiatric institutions to attempt to engineer validation in the role this society provides for the *medical* patient—in which, to be sure, distinctly psychotic patients are presumed to belong. To establish his eligibility for this conventional role, the mental patient must negotiate, using his illness as an instrumentality. He must present his illness to others in a form which they recognize as legitimate, perhaps even exaggerating his portrayal of those behaviors which qualify medical patients for their role. In having to do so, the argument continues, he is often left with little choice but to become sicker or more chronically sick.

The Patient

This section is based primarily on data collected in a small, "open" psychiatric hospital which offered analytically oriented psychotherapy for a fairly selective group of patients. Diagnoses in this population ranged, for the most part, from the

[3] See in this connection, Erik H. Erikson, "The Problem of Ego Identity," *J. Amer. Psychoanal. Assn.* (1956) 4:56-121.

[4] See Talcott Parsons, *The Social System;* Glencoe, Ill., The Free Press, 1951.

severe psychoneuroses to borderline psychoses. The institutional setting lacked the scheduled rigidity of closed hospital routines and allowed for an unusual degree of personal initiative. Since the patients received almost daily individual therapy and were, in a certain respect, volunteers for treatment, who recognized the implications of their patienthood, they could hardly be considered representative of the average ward population. But the experienced clinician will be able to determine to what extent generalizations made from observation of this group apply to patients in custodial institutions, whose contacts with the outside world are more limited. No doubt many of the same social forces act upon patients in any hospital situation, even where behavior is more strictly routinized and confined within the limiting boundaries of a closed ward so that it may seem to reflect the common setting in which it took place rather than the common motivations which produced it. Thus it is possible that the uniqueness of the therapeutic setting in which these observations took place simply affords a more spontaneous picture of social forces operating in any psychiatric hospital.

While doing some sociological work in this setting, the writer took a brief inventory of behavior themes which seemed characteristic of the patient group and which appeared to be among the central motifs of the patients' role behavior.

One may begin by noting certain contradictions implicit in the very act of becoming a mental patient. By accepting hospitalization, the patient makes a contractual agreement to cooperate in a therapeutic partnership: he agrees to want and to appreciate treatment, to be realistic about his need for help, to volunteer relevant information, and to act as reliably as possible upon the recommendations of his therapist. Yet it is widely considered a condition of his illness that he is unable to make meaningful contact with any reality, therapeutic or otherwise. In the grip of these discrepant expectations, his behavior is likely to be a curious mixture of the active and the passive, a mosaic of acts which tend to confirm his competence and acts which tend to dramatize his helplessness. He must test the limits of his own uncertain controls and look for consistent expectations to guide him, as the following fragment from a case history illustrates:

> One of the outstanding characteristics of this patient is his absolute uncertainty about his illness and what is expected of him in the institution and in therapy. He is uncertain whether he actively produces his hysterical states or whether they come upon him without his being able to do anything about them. He does not know whether he is supposed to show his symptoms or suppress them, to "let go" of his impulses and act out or to exert active self-control and "put the lid on." He is afraid that if he does the former, he is psychotic and will be considered too sick for the open institutional setting here; if he does the latter, he will be a pretending psychopath and considered too well to continue treatment here at all. He does not know what he should expect from himself, from other patients, from his sickness, from other people he knows, or even from his therapist. Perhaps his most crucial problem at the moment is to define for himself what are the conditions of his stay here as a patient.

This fragment sums up the bewildering social situation in which the patient must act, and it is not difficult to understand how the final assumption of a consistent social role might represent to him a clarification and partial adjustment. To demonstrate this, I shall try to isolate a few strands of behavior from this complicated fabric.

All children are taught in this culture that it is impolite to stare at or make reference to the infirmities of cripples. So it is interesting to note that the generous impulse of outsiders to overlook a patient's less visible infirmities is likely to put the patient in an instant state of alarm, and to bring urgent assurances on his part that he is severely sick and in serious need of treatment. Patients often bring this topic into conversation on scant provocation and continue to talk about it even when fairly vigorous attempts are made by visitors to change the subject. The patient is likely to describe this as "accepting the realities of his illness," by which he means that he frankly admits the seriousness of

his sickness and refuses to take refuge in some convenient defense that might deny it. Yet to the observer it often appears that this is an attempt to convince *others* of these realities as well as to remind himself, as if he were afraid they would be overlooked entirely. The patient seems to feel it crucial that his illness be accepted as a fundamental fact about himself, the premise on which he enters into relations with others.

Side by side with this severe "honesty," the patient can develop a considerable degree of responsibility in carrying out the therapeutic recommendations of his therapist. And if the hospital tries to foster the patient's social initiative, he may respond with resources that even the therapist did not know were at his disposal. Such initiative is usually in evidence only during certain hospital activities and sometimes appears to belie the very weaknesses which the patient, at other times, displays so insistently. Patients at the hospital in question, for instance, have organized and produced dramatic plays before outside audiences, performing with a skill that surprised professional dramatic observers, and succeeding even when the therapists themselves had severe reservations about the outcome. At a prizewinning performance in a neighboring city, some of the audience were and remained under the impression that the players were members of the medical staff rather than patients of the institution.

Yet as one records this accomplishment, it must be noted that such positive efforts can sometimes be as deceptive as they are surprising, and that, at times, they can produce negative undercurrents that threaten to cancel out the accomplishment altogether. In reporting on the plays performed at the hospital, one journalist noted this. He said that the patients produce and act in plays before paying audiences with a competence which, according to Clifford Odets, who saw one of his plays so performed, is equal to that of any good amateur group. At the same time, the reporter said, one of the doctors had remarked ruefully, "I was very upset when one of my patients, after doing a fine job in the play, went back to the patients' dormitory and tried to set fire to it."

The example is extreme, but it illustrates the conflict a patient encounters in committing himself to positive and constructive activity. Like Penelope, who wove a cloak by day only to unravel it at night, the mental patient often portrays the insecurity of his position by staging, after every advance of this kind, a dramatic retreat into impulsivity and destruction.

Thus at once the patient accepts responsibility for a type of performance rarely asked of the average person, yet is unable to control actions which, in the light of the earlier accomplishment, would seem to be well within his realm of mastery. This seeming paradox is a recurring motif that runs through the whole complex of the patient's role behavior. As has been shown in the case abstract that introduced this section, the patient has potentialities for activity and passivity, for resourcefulness and helplessness, in any given area of action. To organize these into a coherent role pattern, it seems, the patient partitions his hospital world into areas where he considers one or the other of these potential responses specifically appropriate.

In some decisive situations, as has been described, the patient faces his hospital life with remarkable initiative. Yet in others, an overwhelming theme of helplessness seems to dominate his behavior. He is likely to insist, in terms far stronger than the situation would appear to necessitate, that he is unable to control his behavior and must be given a wide license for conduct that is certainly unconventional according to the values prevalent outside the hospital. A patient was asked, "Why did you do that?" His answer, "How should I know? If I knew these things, I wouldn't he here," reflects the values thus emerging in the patient role pattern. Patients have been heard comforting one another by saying, "Of course you can't do it." This process of "giving up defenses" is, of course, presumed to be es-

sential for successful treatment, particularly in intensive analytic therapy, and a certain license for impulsivity and acting out seems to be part of much of psychotherapy in general. But the patient often seems to reserve his right for such license with what appear to be unnecessary claims that he "can't help it."

One might add that whereas clinical evidence indicates that patients often feel a strong guilt at "having let others down," the values of the patient group seldom allow its overt expression—and even supply convenient channels for its projection elsewhere. It is not uncommon for patients to bitterly indict their parents, often for the same weakness they themselves "can't help," sometimes talking as if a kind of deliberate conspiracy was involved in the events that led to their own illness. The weakness of this logic seems evident even to those who use it most persistently, which again indicates that the social usages which allow its expression must have an important social function to the patient group. If a little harsh, it may be one way to deny one's responsibility for being sick, while nevertheless accounting for one's illness in terms that are current outside the hospital walls.

The point is that most of the persons a patient encounters in the hospital, certainly the other patients, are perfectly willing to acknowledge that ego deficiencies are not his "fault" and that he is often compelled to act without the benefit of sufficient controls. To what audience, then, does he address his continual protest that he has the *right* to some license and can't help the fact that he is sick? Largely, one begins to think, these assertions are broadcast not to the audience assembled in the confined orbit of the hospital at all—but to the omnipresent public which, as shall be seen, fails to validate his commitment to therapy. To assume that hospital walls or the implicit ideology of psychiatric institutions protect the patient from this audience would be an unfortunate oversight. The image of the public audience is firmly incorporated within the patient himself, and this image is constantly reinforced by newspapers, movies, radio, and television. The specialized values which psychiatry introduces into the hospital setting cannot entirely overcome the fact that the patient remains sensitive to current public notions about mental illness, and, on certain levels of awareness, even shares them in substance.

What does the outside audience ask of the patient—and its internalized image make him ask of himself? Essentially, he is asked to justify his voluntary retirement to a hospital by demonstrating that he *needs* it, by displaying a distinct illness requiring highly specialized help. The reason for a person's therapy in a residential setting is obviously the wish on everybody's part that he develop adjustive initiative. Yet if large parts of society doubt his claim to illness when he appears to have a certain competence—when, for instance, he rehearses healthy modes of behavior on or off the stage—he is left in the exposed position of one who has to *look* incompetent even while learning to become the exact opposite. A few minutes before going on the stage, a patient-actor announced, "It is a tradition here that the show *never* goes on!" This tradition is of particular interest because it has no basis in fact whatever. The show in question did go on, as had all of its predecessors. Yet even in the act of positive accomplishment the patient feels it important to repeat that failure is the norm among mental patients, for he always anticipates the question, "Look here, if you can do these things so well, why are you here?"

This prominent theme of helplessness which runs through the patient's verbal and behavioral repertoire again reasserts the basic paradox. For while much of the time he may display a passivity that almost suggests disability, he shows a certain ingenuity in organizing his passive behavior strategically; he can put considerable energy into maneuvers which show him to be helpless; in short, he can go to ample expense to give the impression of one who has nothing to expend. This does not imply, of course, that the patient is deliberately staging a deceptive

performance. On the contrary, it suggests that the psychological needs which motivate such behavior are as compelling, in a certain way, as those considered to be anchored somewhere in the dynamics and genetics of his illness, and, in fact, tend to reinforce them.

In the absence of clear-cut organic symptoms, a "real" illness which "can't be helped" is the most precious commodity such patients have in their bargaining with society for a stable patient role. It is the most substantial credential available in their application for equal rights with the medical patient, and as such, may come to have an important social value to them. The fatal logic of this may be that the patient will find his social situation better structured for him if he gives in to his illness and helps others to create an unofficial hospital structure which supports the perpetuation of patienthood.

Social Uncertainty

Although all human groups rely heavily upon the mechanisms they develop to suppress deviant behavior, among the most crucial measures of any society are the provisions it makes for absorbing certain kinds of deviance into its structure. Societies often accomplish this by placing given individuals—usually those whose deviancy is not considered deliberate—in special statuses where their otherwise invalid behavior becomes the expected and legitimate mode of conduct.

In a well-known analysis, Talcott Parsons argues that illness is a form of deviance which the culture shelters in this manner.[5] By setting role expectations for the ill person which both exempt him from his usual social duties and assure that he will return to them as soon as possible, society effectively neutralizes the onus his failure to perform would otherwise imply. The conditions of this special sick role, as Parsons sees them, are four: First, the sick person is exempted from certain of his normal social obligations. Second, the sick person is considered unable to recover by an act of conscious will; that is, he "can't help it." Third, the sick person is considered obligated to *want* to get well, to cooperate with a physician in achieving recovery, and to accept the protection of the sick role only so long as it is therapeutically necessary. Fourth, the sick person is regarded as in need of technically competent help, which implies that accepting the status of "sick person" is conditional upon accepting the status of "patient."

When sociologists speak about societies "doing" something—providing roles, entertaining expectations, and so on—they take for granted that the acts in question are matters of general public agreement, are institutionalized by consensus. One might ask, then, on the basis of what criteria do persons qualify for the sick role? Like the military physician who must determine from day to day which of the many men who report to him are *really* sick, the public at large must have some generally accepted standards for deciding who is eligible for the sick role exemptions. The sick role, of course, is not granted only out of sympathy for a person's discomfort: it is granted as factual recognition that the person is, in fact, *unable* to carry out his normal duties. The first of these criteria, then, to follow Parsons' logic, is that the person must be at least partially disabled either because of the severity of the illness or the requirements for cure. Furthermore, the patient's disability must be considered one that he is unable to erase by a deliberate exercise of will, his willingness and ability to "get well as soon as possible" must remain unquestioned, and his condition must be regarded as within the province of a qualified therapeutic profession. In fact, in most medical practice it is the physician, acting in the name of society, who certifies his patient as "really" ill.

This brings up an uncomfortable argument. Although the public generally accepts the physician's verbal certificate as indication of legitimate physical sick-

[5] Talcott Parsons, "Illness and the Role of the Physician: A Sociological Perspective," *Amer. J. Orthopsychiatry* (1951) 21:452-460. See also reference footnote 4, Ch. 10.

ness, it continues to doubt the medical legitimacy of many forms of mental illness and often fails to accept the mental patient as a qualified candidate for the sick role.

Recent evidence indicates that, despite the public's growing acceptance of psychiatry, current attitudes toward mental illness fall considerably short of the enlightened attitudes promoted in popular publications. The results of these studies have not yet been made available except in scattered summaries, but certain conclusions can be drawn from them that throw the present situation of psychiatry specifically and the field of mental health generally into a fairly harsh focus.[6]

It appears that on the surface the public has developed reasonably tolerant attitudes toward the mentally ill and even a hesitant respect for the practice of psychiatry. People understand the need for increased psychiatric facilities, appreciate the enormity of the mental health problem, and agree that mental illness is a condition requiring specialized treatment and competently trained help. Yet underneath the pleasant surface of these enlightened principles, people have little idea how to recognize the concrete problems that these principles encompass.

The average person, it seems, cannot identify mental illness when he sees it, cannot recognize the symptoms that indicate it, and remains quite uncertain about the very meaning of the term when pressed for a definition. He continues to resist the notion that a person can be mentally ill and not entirely "out of his mind," although willing to accept illness as legitimate if the patient is a potential danger to the community and is securely committed to a custodial institution.[7]

In practice, people make it clear that they do not generally regard behavior as proof of mental illness, unless three interrelated conditions obtain. First of all, they look for a breakdown of intellect, an almost complete loss of cognitive functioning or, in short, a loss of reason. . . . Second, people expect, almost as a necessary consequence of this loss of rationality, that the behavior called mental illness must represent a serious loss of self-control, usually to the point of dangerous violence against others and certainly to the point of *not being responsible for one's acts*. . . . Finally, people feel that, to qualify as mental illness, behavior should be inappropriate—that is, neither reasonable nor expected under the particular circumstances in which the person finds himself.[8]

There seems to be some public agreement that persons not totally psychotic may have "nervous disorders" or other behavioral difficulties. But it is generally felt that these conditions do not amount to "real" sickness—one of the tests being, apparently, that mental illness is not legitimate if one can recover from it—and do not require any specialized help other than consultation or simple encouragement. For this purpose, competent help is available from friends, ministers, and general medical practitioners as well as psychiatrists—perhaps in that order of importance.

Thus the psychiatrist continues to deal with his patient in a context of rather general public uncertainty, if not outright mistrust. He cannot share the physician's license for simply naming his patient to the sick role, confident that the patient's community will substantiate the claim. The psychiatrist can only proceed tentatively: his assurances about a patient's condition or need for special attention, particularly if that patient has not slipped off into a state of colorful sickness visible to the untutored eye, are often contradicted, often ignored, and seldom regarded as the final word of a specialized authority.

[6] The reference here is to a study conducted by the National Opinion Research Center, University of Chicago. It is based on 3,500 intensive interviews with a representative cross section of the American public. A book describing the results of this study is being prepared by Shirley A. Star, Senior Study Director of the NORC, but in the meantime two short reviews of the general findings are available: Shirley A. Star, "The Public's Ideas about Mental Illness," a paper presented to the Annual Meeting of the National Association for Mental Health, Indianapolis, November 5, 1955; Shirley A. Star, a report on public attitudes in *Psychiatry, the Press and the Public;* Washington, D. C., Amer. Psychiat. Assn., 1956; pp. 1-5.

[7] This raises a further problem of interest, which the present paper cannot take time to discuss. In a certain sense it is true that severely psychotic patients may be considered legitimately ill by the general public, but this is at best a special case of the sick role. For it is widely held that mental illness is not legitimate if recovery is possible. Thus, commitment to a custodial institution is regarded far more as leading to a state of permanent constraint than to a provisional role which the patient takes while under treatment which will result in a resumption of normal social obligations.

[8] Shirley A. Star, "The Public's Ideas about Mental Illness," reference footnote 6. The italics are mine.

Traditional medicine, of course, has had centuries to attract the respect of society and can point to a continued series of new and successful forms of treatment. But it may take more than just time for such authority to be transferred to psychiatry. For it may well be that the very conceptual frameworks which society has acquired through its acceptance of medical and other scientific phenomena do not lend themselves to an understanding of psychiatric subject matter. Injury or disease is conceived as something which has palpable substance, can be located somewhere on the physical organism, can be diagnosed according to an existing body of knowledge, and can be treated with fairly standard instruments in fairly standard ways. In comparison with this set of expectations concerning medical care, the psychiatrist can offer very little. In his role as therapist, he specifically deals with the symbolic, the unique, the personal aspects of human experience, and while his medical arsenal can supply a few standard diagnostic tests, some somatic therapies, and an increasing variety of pills, there is nothing approximating a blueprint after which he can fashion his treatment. When he deals with the dynamics of mental illness, every step he takes is novel and without a precise precedent. As a consequence, many strata of society cannot regard mental therapy as an honest concern of medicine, which, after all, in its traditional objectivity, is supposed to be oriented to substantial and material matters rather than to the intangibles of human experience. If the public makes this distinction too readily, it is using criteria to do so which medicine has advocated for centuries.

The ill person, then, in committing himself to psychiatric treatment and in trying to develop a systematic patient role, is taking on modes of behavior which make little sense to those he adopts them for. It is clear that the public remains skeptical about his claims of sickness, and leaves him in the uncertain position of having to engineer new kinds of access to a legitimate sick role, or, perhaps, turning away altogether into other channels of expression for his deviant motivational needs. How many are shuffled off into marginal areas of society to find a deviant group setting—into criminal gangs, religious sects of one sort or another, into "artists" colonies or hobo camps—one can only guess. However, every physician will agree that an impressive clue to the alternatives of becoming a mental patient is provided by the number of persons who have to translate their discomfort into physical ailments before they are able to recognize it at all.

The Dilemma

This problem may gain in relevance if one turns from the broader organizational aspect of the patient role and inquires briefly about the social career of the particular patient.

The sick role which Parsons visualizes is a transitory one. It is easy to acquire if eligibility is established, easy to abandon once its functional value is exhausted, so that the experience of being sick poses no necessarily abrupt breaks in the continuity of the medical patient's life. But the mental patient is in double jeopardy. He acquires recognition as a "sick" person only at a considerable emotional price, if at all; later, he is able to withdraw from this recognition only with extreme difficulty, for he then faces the widespread conviction that legitimate mental illness cannot be completely cured anyway.[9] Moreover, the mental patient's treatment is often designed to effect comprehensive ego changes rather than simply to restore him to his former state of health, so that on several counts his experience with sickness may become crucial to his developing sense of direction and identity. The danger is that patienthood may become a model for his image of the future rather than a provisional shelter in which he resets himself for a life already in progress. In some cases of lifelong difficulty, the patient's efforts to be recognized as a patient

[9] An interesting fictional account of this difficulty can be found in Eileen Bassing, *Home Before Dark;* New York, Random House, 1957.

may be the first definite attempts he has ever made to establish himself in a clear-cut social identity, while his adjustment to the hospital community may be the first successful one he has ever made.

For when the patient has to seek definition as acutely sick and helpless in order to achieve a measure of public validation for his illness—and simultaneously has to use all his remaining strengths to struggle against that illness—a dilemma is posed which he may resolve by simply giving up the struggle altogether and submerging himself in the sick definition permanently. The temptation to embrace such a definition, despite its lack of social approval—perhaps even because of it!—may be quite persuasive, as one of Dostoievski's characters points out:

> Oh, if I had done nothing simply from laziness! Heavens, how I should have respected myself then! I should have respected myself because I should at least have been capable of being lazy; there would at least have been one positive quality, as it were, in me, in which I could have believed myself. Question: What is he? Answer: A sluggard. How very pleasant it would have been to hear that of oneself! It would mean that I was positively defined, it would mean that there was something to say about me. "Sluggard"—why, it is a calling and vocation, it is a career. . . . I should have found for myself a form of activity in keeping with it. . . .[10]

This poses a further dilemma for psychiatry. The medical conditions which, it is currently believed, provide the optimal clinical setting for treatment may at the same time be social conditions which put a stamp of permanence on the illness. The danger that the patient will find himself a permanent "form of activity in keeping with" his momentary patienthood, while trying to engineer access to the medical patient role which psychiatry advocates for him, cannot be overlooked when psychiatrists consider their high readmission rates and their constant struggle with chronicity. It is important to realize that the patient's tendency to see himself as a medical responsibility and make symbolic application for the allowance this implies receives its initial impetus and support from psychiatry, even as psychiatry struggles for its own recognition within medicine. Practically every term in psychiatric usage which identifies patients, treatment, therapeutic settings, and hospital organization is borrowed from medical practice. Certainly a great number of psychiatric procedures are fashioned after medical models, while the physical facilities provided for the treatment of mental patients often duplicate those of the conventional hospital. To the psychiatrist himself, this may be largely a matter of convenience and training, but to the patient it is likely to have an implicit social logic: given the setting, it is only appropriate that he entertain the role expectations of any medical patient.

Perhaps even more important is the manner in which mental mechanisms are likely to be conceptualized by the psychiatrist and his patient alike, providing these mechanisms with an illusion of substance that renders them akin to anatomical organs. In constructing a workable model of psychic processes, psychiatry has tended to visualize the human mind by the use of intricate structural analogies—beginning, perhaps, with Freud's use of topographical terms and continuing throughout a literature in which the ego is likened to a building or machine and disorder is likened to a failure of supports, a weakening or collapse of foundations, and so on. These analogies may well serve the needs of psychiatry to order the dynamic problems it encounters; but they also tend to buttress the patient's already strong tendency to attribute to his illness —in those cases where he cannot actually blame verifiable organic changes—a quasi-organic structure and substance. Substantial disorders, of course, traditionally lie in the province of the surgeon or the practitioner who coaches the organism back to health. Thus, it should be a matter of small surprise if the analogy is taken too seriously and patients enter the therapeutic setting with the passive attitude that they have come to be "fixed,"

[10] F. M. Dostoievski, "Notes from Underground," pp. 442-537; in *A Treasury of Russian Literature*, edited by Bernard Guilbert Guerney; New York, Vanguard, 1943; p. 454.

or with the comfortable notion that mental illness is something which has "happened" to them, something in which they are only indirectly implicated, like an "enemy" invasion of germs.

When this disparity between popular attitudes and medical values in psychiatry is pointed out, it is usually proposed that a massive program of public education be initiated in order to create public attitudes receptive to psychiatric realities, thereby creating a consistent patient role for the mentally ill. However, the sociologist may well suggest that these proposals be considered in the light of two crucial issues.

The first of these is the simplest. Would psychiatry be adequately serving its own interests if it *were* able to promote the mental patient's eligibility for the conventional sick role? This role has its roots in a fairly precise line of demarcation between the sick and the well, in that those people who are considered ill enough to need specific exemption are set aside into an identifying social status and expected to perform a fairly well established social role. Medically speaking, there may be some reality to this largely artificial distinction: the physician's practice, at least, is not unduly hampered if the community recognizes different sets of expectations for those whom he regards as his patients. However, to make this clear a social distinction between mental health and mental illness, between the mental patient and the normal citizen, not only puts the psychiatrist in the uncomfortable position of revealing the uncertainty of his knowledge about these groups of phenomena; it puts the patient who does not and should not wish to claim considerable disability into a position of grave jeopardy. Psychiatrists usually prefer to visualize human behavior as falling on a spectrum, in which degrees of illness are recognized as gradations between the polar states of ideal health and total collapse, and thus psychiatrists should be acutely sensitive to the dangers of marking some point on this spectrum as the line between health and illness.[11] Many of them hope to provide preventive and other services to those who remain on the healthier end of the spectrum, for example, and will have every reason to resist the implication that those regarded as in some degree "ill" require special social license. At the present state of knowledge, psychiatrists may find it to their advantage if the state of *being sick enough to need help* and the state of *needing exemptions from normal social duties* are not articulated too clearly within the same role.[12]

The second issue is whether or not psychiatry, especially as it branches out into child guidance and preventive psychiatry, can ever support the contention that it remains an ideological branch of medicine. This is not to question who should carry the *legal* responsibilities for treatment of mental disorders, but to consider how effective scientific analogies are for public education. The public's skepticism about psychiatry as a medical tradition, it must be realized, is not simply a consequence of ignorance or emotional resistance; it has a fairly wide basis in fact and is presented in a framework of fairly sound logic. It cannot be the purpose of this paper to cite the fundamental differences which exist between psychiatric and medical practice on the one hand, and between the mental and medical patient on the other. I am here talking about the *social forms* which the public creates to handle the problem of illness, and considering whether or not a convincing enough logic is available to persuade the public that mental illness belongs to the same social classification as the distinctly organic. Such a logic would have to explain why most medical treatments can become increasingly routinized while psychotherapy must remain individualized

[11] See, in this connection, a report by John Spiegel in *Psychiatry, the Press and the Public,* reference footnote 6, pp. 13-18.

[12] This is of outstanding importance in military psychiatry, for instance, where *failure* to offer exemptions to clearly sick persons is often regarded as the best therapeutic measure available. This point was made by Bruce L. Bushard in "The Army's Mental Hygiene Consultation Service," a paper read to the Symposium on Preventive and Social Psychiatry, held under the auspices of the National Research Council and the Walter Reed Army Institute of Research, Washington, D. C., April 15-18, 1957.

and personal. It would have to explain why the objects of physical and mental therapy are basically different, the former restoring the patient to an earlier state of health, the latter changing the very resources with which the patient faces life. Most important, it would have to establish a certain number of predictive criteria, on the basis of which society could estimate the likelihood of recovery in particular cases, the length of treatment required, and the pain or complication the patient could reasonably expect in the meantime. For the sick role is issued by society to help maintain the functional coherence of social processes. It is provisionally assigned, with an implicit expiration date in mind which can be at least vaguely anticipated. To the patient's community, therefore, it is a matter of profound importance whether he asks for a certain period of exemption to recover from an illness or seeks a blank check in order to undergo the uncertainties of psychiatric treatment. The latter instance changes the whole basic relevance of the sick role to the social group which validates its use.

True, psychiatric procedures may, in time, achieve a degree of standardization and a body of knowledge which will make this grouping of medical and mental patients into a single social category reasonable from the public's point of view. Even if one avoids the argument as to whether such a degree of standardization can ever be achieved—or will be good therapeutic practice if it is—it is clear that in the meantime psychiatry's continued attempt to use medical values in the treatment of mental illness may result in continued patient insecurity.

It may then be argued that the time has come for psychiatry to review and perhaps revise its general approach so as to create a more realistic position for the mental patient in society, one which relies less heavily on medical claims and instead takes more firmly into account the social realities that underlie public resistance to the whole ideology of psychiatric practice.

This might call for the sort of re-evaluation which appears to be taking place in certain European treatment centers and is spreading with the growth of the field of social psychiatry. In such centers psychiatrists have joined with social workers, psychologists, and other specialists in the field of social relations to produce a therapeutic atmosphere which relies less on medical analogies than is generally common in the United States. The emphasis seems to be on *re-education and resocialization* rather than on therapy, on *development and training* rather than on reintegration of ego processes, on the *therapeutic community* with its roots in outside society rather than on the hospital with its specialized culture. Certain European institutions, notably the day-hospital which has spread throughout England and the Netherlands, expose patients to a schedule in certain respects far nearer to that of a student than that of a medical patient, while special trade schools and training centers, supervised by clinicians, take over a large bulk of the borderline and even chronically psychotic cases which might be permanently hospitalized or neglected altogether in the United States. It may be that this combination of an educational approach to mental illness and its complementary role of *special student* will provide the richest clue to a clear-cut social position for those now regarded as mentally ill.

It must be admitted in conclusion that the sociologist looks at the patient from a special viewpoint, burdening rather slim threads of evidence with heavy arguments and enjoying a speculative freedom which cannot be shared by those who take the actual and continuing responsibility for treating mental illness. However, the clinician's understanding of the therapeutic environment he creates for his patient may be sharpened by the concepts of the social sciences, particularly where these concepts help to view both patient and psychiatry as participants in the cultural context of social life. The sociologist must point out that whenever a psychiatrist makes the clinical diagnosis of an existing

need for treatment, society makes the social diagnosis of a changed status for one of its members. And while the clinician must insist that the treatment which follows and the setting provided for it have to be geared to the inner-dynamic realities of the patient's illness, the sociologist proposes that recovery may also depend upon gearing the ongoing treatment to the social realities of the patient's changed status.

DEPARTMENT OF PSYCHIATRY
WALTER REED ARMY INSTITUTE OF RESEARCH
WALTER REED ARMY MEDICAL CENTER
WASHINGTON, D. C.